BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of ARM 37.82.101 pertaining to Medicaid eligibility	)))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On November 20, 2007, at 11:00 a.m., the Department of Public Health and Human Services will hold a public hearing in the Wilderness Room, 2401 Colonial Drive, Helena, Montana, to consider the proposed amendment of the above-stated rule.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process (including reasonable accommodations at the hearing site) or who need an alternative accessible format of this notice. If you need an accommodation, contact the department no later than 5:00 p.m. on November 5, 2007. Please contact Rhonda Lesofski, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena MT 59604-4210; telephone (406)444-4094; fax (406)444-1970; e-mail dphhslegal@mt.gov.

3. The rule as proposed to be amended provides as follows. New matter is underlined. Matter to be deleted is interlined.

37.82.101 MEDICAL ASSISTANCE, PURPOSE, AND INCORPORATION OF POLICY MANUALS (1) Subject to applicable state and federal laws, regulations and rules, the Montana Medicaid program pays for covered medically necessary services for persons determined eligible by the department or its agents.

(2) The department adopts and incorporates by reference the state policy manuals, namely the Family Medicaid Manual and the Aged Blind Disabled (ABD) Medicaid Manual governing the administration of the Medicaid program dated January 1, ~~2007~~ 2008. The Family Medicaid Manual, the ABD Medicaid Manual, and the proposed manual updates are available for public viewing at each local Office of Public Assistance or at the Department of Public Health and Human Services, Human and Community Services Division, 111 N. Jackson Street, Fifth Floor, P.O. Box ~~202952~~ 202925, Helena, MT 59601-~~2952~~ 2925. The proposed manual updates are also available on the department's web site at www.dphhs.mt.gov/legalresources/proposedmanualchange.shtml.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-131, 53-6-141, MCA

4. The Montana Medicaid program is a joint federal-state program that pays

medical expenses for eligible low-income individuals. To qualify for the Montana Medicaid program, an individual must meet the eligibility requirements set forth in ARM Title 37, chapter 82. Additionally, the Family and the Aged, Blind and Disabled (ABD) Medicaid manuals set forth information about the eligibility requirements for Medicaid that is more detailed than that in administrative rules. These state policy manuals are published by the department to provide guidance to employees of the local Offices of Public Assistance who determine Medicaid eligibility.

ARM 37.82.101 adopts and incorporates by reference the Medicaid policy manuals. By incorporating these manuals into the administrative rules, the department gives interested parties and the public general notice and an opportunity to comment on policies governing Medicaid eligibility. Additionally, as a result of the incorporation of the manuals into the administrative rules, the policies contained in the Family Medicaid manual and the ABD Medicaid manual have the force of law in case of litigation between the department and a Medicaid applicant or recipient concerning the applicant or recipient's Medicaid eligibility.

ARM 37.82.101 currently adopts and incorporates by reference the Medicaid policy manuals effective January 1, 2007. The department proposes to make some revisions to these manuals that will take effect on January 1, 2008. The amendment of ARM 37.82.101 is therefore necessary in order to incorporate into the Administrative Rules of Montana the revised versions of the policy manuals and to permit all interested parties to comment on the department's policies and to offer suggested changes. It is estimated that changes to the Family and ABD Medicaid Manuals could affect 78,618 Medicaid recipients. Manuals and draft manual material are available for review in each local office of public assistance and on the department's web site at www.dphhs.mt.gov. Following is a brief overview of the changes being made to each manual section for the Family Medicaid manual and the ABD Medicaid manual.

ABD Medicaid Manual

MA 002 Medically Needy -- The Sixtieth Montana Legislature appropriated $1.1 million of state special revenue dollars for fiscal years 2008 and 2009 to increase the amount of income that is disregarded in determining eligibility for the medically needy category of Medicaid. This appropriation will result in an additional $3.3 million in federal Medicaid matching funds, for a total of $4.4 million additional funds for the biennium. Persons or households whose income exceeds the maximum income limit for Medicaid eligibility although they otherwise qualify may become eligible for Medicaid as medically needy individuals by incurring medical expenses equal to the difference between the medically needy income limit and the person or household's net countable income. The difference between the medically needy income limit and the household's countable income is known as the household's medically needy incurment. If a household's countable income is lower, its incurment will be smaller, and it will be easier for the household to qualify for Medicaid. A household's countable income is calculated by subtracting certain

income disregards, such as the $20 general income disregard or the $65 work expense disregard, from gross income. An increase in the amount of income disregarded in computing a household's income makes it easier for households to qualify for Medicaid as medically needy individuals.

The department is implementing the Legislature's mandate to count less income by allowing an additional deduction of $50 per month to be subtracted from each medically needy household's net countable income when determining the medically needy incurment. The new deduction will be $50 per month for all households, regardless of household size, beginning August 1, 2007. The deduction will increase to $100 per month effective July 1, 2008. The department chose to implement the Legislature's mandate to count less income by adding a deduction rather than by raising the medically needy income limit because the medically needy income limit is based on the categorically needy income standards for Family Medicaid. Thus, an increase in the medically needy income limits would require an increase in the Family Medicaid categorically needy income standards which would make more families eligible for regular (nonmedically needy) Medicaid. This would increase Family Medicaid expenditures approximately $7 million annually. The department therefore opted to use a deduction from income instead. The department chose to deduct the same amount from the countable income of all households regardless of household size or other factors because this is simpler than adjusting the deduction amount depending on household size or other factors.

MA 105-1 Disability Determination Overview -- In order for an individual to qualify for Medicaid, he or she must first fit into a coverage group. An individual qualifies for Medicaid under the disabled coverage group if the individual meets the disability criteria used by the Social Security Administration (SSA). In some instances, SSA does not make a disability determination, such as in the case of an individual who does not meet financial requirements of the Supplemental Security Income (SSI) program and does not have adequate quarters of work to qualify for "regular" SSA benefits. DPHHS has a disability determination contractor that normally makes disability determinations in these situations. However, in the past, determinations of developmental disability by the Developmental Disabilities Program (DDP) of DPHHS were also recognized. The agency recently discovered that DDP uses a somewhat different set of state criteria to determine developmental disability than SSA does. Therefore, a person could be determined developmentally disabled by DDP, but not fit the SSA criteria. For this reason the department must stop recognizing DDP determinations as verification that an individual is disabled according to SSA criteria. All individuals not determined disabled by SSA, or by their death, will be processed for a disability determination through the state's disability determination contractor.

MA 400 Resources Overview -- In some cases aliens who are admitted for permanent residence in the United States have been sponsored by an individual for entry into the country. When a sponsored alien applies for Medicaid coverage, the resources of the sponsor are deemed available to the sponsored alien. The amount of resources deemed available to the sponsored alien is determined by determining

the total amount of the sponsor or sponsors' resources and subtracting from that amount the applicable Medicaid resource limit, that is, $2,000 for an individual or $3,000 for a couple. The department proposes to make certain changes to the policy governing deeming of a sponsor's resources in order to make it simpler.

If the alien's sponsor is married and living with his or her spouse, the resource limit for a couple, $3,000, is deducted from the total resources of the sponsor and the sponsor's spouse to determine the amount of resources deemed available to the alien. Under the current policy, however, if a sponsor's spouse with whom the sponsor resides is also a cosponsor of the alien, each spouse is allowed the resource limit for an individual, and a total of $4,000 is deducted from their total resources instead of a deduction of $3,000 for a couple. In such a case, due to the higher deduction, fewer resources are deemed available to the sponsored alien. The manual currently does not specify what deduction is used when an alien has two sponsors who are not married to each other. In order to make the policy on deeming less complicated, it is now being revised to provide that the resource limit for a couple will be used when a sponsor's spouse with whom the sponsor resides is also a cosponsor of the alien. Additionally, the manual will now provide that two separate sponsors not married to each other are treated the same as a sponsor and his or her spouse, so the deduction for a couple, $3,000, will be used in that case also.

MA 401-1 Resource Ownership/Accessibility/Equity Value -- The definition of when an asset is considered available has been restated to clarify that a resource is considered available if the individual has either a legal or equitable interest in the asset, and the resource is counted if the individual has the legal or equitable ability to access the funds or to convert noncash property into cash, regardless of their practical ability to do so. This is merely being added for clarification and does not represent a change in policy.

MA 402-1 Countable and Excluded Resources -- This section of the manual currently sets forth policies for counting or excluding annuities owned by Medicaid applicants or recipients but does not specify how to treat annuities owned by the eligible spouse of a Medicaid applicant or recipient. An eligible spouse is defined as an aged, blind, or disabled spouse of a Medicaid applicant or recipient where neither spouse is institutionalized or has been found eligible for Home and Community Based Waiver (Waiver) services. If one member of a couple is institutionalized or found eligible for Waiver services, however, or if Waiver eligibility is being determined, the applicant/recipient's spouse (whether ABD or not) is considered a community spouse rather than an eligible spouse. This section is now being revised to specify that annuities owned by an eligible spouse will be treated the same as annuities owned by a Medicaid applicant or recipient, because it is logical to apply the same criteria for excluding annuities owned by an eligible spouse as is used for annuities owned by an applicant or recipient.

The manual currently does not set forth a policy for determining the value of an annuity. It is necessary to add provisions for determining the value of annuities to

the manual so that all employees making Medicaid eligibility determinations are using the same method of evaluating annuities and so interested parties can ascertain the department's policy by referring to the manual. The manual is being revised to state that the value of an annuity is determined by multiplying the total annual payments by the period of the annuity remaining on the date for which value is being determined. If the period of the annuity is based on an annuitant's lifetime, the annual payments are multiplied by the annuitant's life expectancy per the table in the policy manual. If the annuity is a "period certain" annuity, then annual payments are multiplied by the annuitant's life expectancy or the period certain, whichever is less. The department has determined that this is a reasonable method of calculating the value of an annuity. Nevertheless, the applicant or recipient will be given an opportunity to rebut the value of an annuity calculated by this method by providing verified purchase offers from disinterested sources in the business of buying annuities.

The manual provides that irrevocable funeral agreements are excluded resources. The manual currently specifies five criteria that must be satisfied in order for a burial agreement to be considered irrevocable and excludable. This provision is being revised to add a sixth requirement that the funeral agreement must comply with 53-6-169, MCA, which provides that if the funeral agreement originally held funds in excess of $5,000, any funds not expended for the funeral expenses are payable to Montana Medicaid. The requirement for the agreement to comply with 53-6-169, MCA, ensures that the funeral home with whom the agreement is made is aware of the obligation to refund excess funds to Montana Medicaid, which may result in more funds being returned to Montana Medicaid.

The manual currently provides that in order for a contract-for-deed to be excluded as a resource, the contract must be amended to provide that all payments due after the recipient's death shall be made to the Montana Medicaid program. The policy is being changed to require instead that the Medicaid recipient irrevocably assign to the Montana Medicaid program any interest the recipient has in the contract after the Medicaid recipient's death in order for the contract to be excluded. This change is being made because it was brought to the department's attention that the amendment of the contract-for-deed would require the consent of the purchaser. If the purchaser did not cooperate, the contract could not be amended and the contract therefore could not be excluded. The new policy requiring the assignment of payments under the contract rather than amendment of the contract allows the Medicaid recipient to comply with the criteria for exclusion without the cooperation of the purchaser.

The manual currently provides that property necessary for self-employment is an excluded resource. This provision is being amended to specify that property necessary for self employment will be excluded only if the owner is materially participating in the operation of the business at least ten hours per week throughout the year, claims the endeavor is self-employment, and, if filing income taxes, reports the income on Schedule C, F, or SE. If these criteria are not met, the property will be treated as income producing property rather than self employment property, and

the property will then be excluded only if the requirements for the exclusion of income producing property are satisfied. The addition of objective criteria such as ten hours per week of material participation will make it easier to determine whether property is self-employment property or income producing property.

Discussion of IRA owners being required to exercise options to access periodic payments from the accounts has been removed, because it is unnecessary. The only time this would be applicable to an IRA is if the IRA was in the form of an annuity, in which case the annuity policy would apply. Instead, a statement has been added that applicants and recipients are required to exercise available options to receive periodic payments from retirement accounts that are excluded as resources.

MA 404-1 Asset Transfers -- This section has been enhanced to clarify that transfers that are alleged to have been made exclusively for purposes other than to qualify for medical assistance must be carefully evaluated, and such exclusive purpose must be completely unrelated to any plans to preserve assets for the use of nondependent family members (or others). This merely represents a clarification, not a change in policy. A change is being made in regard to what constitutes compensation for a transfer of assets, however. Currently the manual states that compensation does not include services or gifts previously provided to the applicant or recipient out of love or concern without expectation or promise of payment. The definition of compensation is being revised to specify that services or gifts previously provided out of love or concern without expectation and promise of payment do not constitute compensation. This change is being made to make the department's policy consistent with the federal Supplemental Security Income regulation on transfers of assets at 20 CFR 416.1246(c), which provides that compensation is money, property, or services provided prior to the transfer pursuant to a legally enforceable agreement. If the person who furnished the services or gifts had an expectation of payment but there was no promise of payment by the applicant or recipient, a legally enforceable agreement does not exist. The revision of the policy to require a promise to pay as well as an expectation of payment ensures that only services or gifts furnished pursuant to a legally enforceable agreement will be considered compensation for a transfer of assets.

A new policy regarding personal care contracts is being added to this section. The manual will now specify that when a Medicaid applicant or recipient has entered into a personal care contract with a third party other than the nursing home, assisted living facility or adult foster home in which the applicant resides, any payment to the third party for services which are duplicative of services already included in the services package being received in the person's living situation is considered an uncompensated asset transfer. This policy is necessary because the department has recently become aware of an increase in the number of personal care contracts entered into between Medicaid applicants or recipients and family members under which relatives are being paid for performing tasks which the facility is required to perform, such as feeding the applicant at meal time or washing the applicant's clothes. Such contracts may be used as a way to transfer money to a relative while

avoiding the appearance of an uncompensated transfer. The department proposes to adopt this policy because it is not reasonable for an applicant or recipient to use resources which could be used to pay for nursing home care or other medical expenses to pay for services that the facility is being paid to provide.

Additionally, the manual will state that if payment is made to a third party for services which do not duplicate services already required to be provided, the amount of the payment must be reasonable according to usual and customary charges for such services provided by persons in the business of providing such services for a fee. This policy is also necessary to ensure the person performing the personal care contract is being paid only a reasonable amount rather than the personal care contract being used to transfer money to a relative while avoiding the appearance of an uncompensated transfer.

MA 404-2 Penalty Periods for Asset Transfers -- The average cost of nursing home care in Montana is used to calculate penalty periods for uncompensated asset transfers made by nursing home and Home and Community Based Waiver recipients. The federal Medicaid statute at 42 USC 1396p(c) mandates that the penalty period for a disqualifying transfer of assets be computed by dividing the value of the assets transferred without compensation by the average monthly cost to a private patient of nursing facility services at the time of application in the state where the person is applying for or receiving Medicaid. The average private pay cost is recalculated annually. The average is now being changed to reflect the results of the most recent survey of private nursing home rates in Montana, as conducted by the department's Senior and Long Term Care Division. The updated average is $4680 per month, increased from the 2007 average of $4,512. The higher the average private pay cost of care is, the shorter the penalty period will be, so the increase in the private pay rate will result in Medicaid paying for nursing home care sooner for applicants who have made uncompensated transfer of assets. The fiscal impact of the increase in the private pay rate is expected to be approximately $43,000 annually in total Medicaid expenditures, of which approximately $30,100 is general fund.

MA 501-2 Native American Income -- In accordance with federal law, lease payments received by Native Americans on individually owned trust or restricted land up to $2000 per calendar year are excluded as income. 25 USC section 1408 provides that such payments shall not be considered income in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program. Medicaid is one of the programs authorized by the Social Security Act. Until now the department has followed the practice of the SSI cash assistance program of applying only payments received during the time an individual was receiving assistance against this $2,000 exclusion. This practice is not required by the language of 25 USC 1408, however. This practice also creates a disincentive to maintain ongoing Medicaid eligibility and penalizes those who maintain Medicaid year round. Additionally, it is simpler to exclude lease payments up to $2,000 per calendar year without regard to the applicant or recipient's eligibility status in the month when the payment was received. The fiscal impact of this policy is

anticipated to be zero, as any minimal increase in expenditures would be offset by the elimination of administrative complexities and a decrease in eligibility determination errors.

MA 503-1 Self-Employment Income -- Differentiating between self-employment and hobbies, and between self-employment income and passive income from income producing property is often difficult. Whether an activity represents self-employment or not can make a difference to whether some resources are countable or excluded, and whether income is considered earned or unearned; both may make the difference between an individual qualifying for Medicaid or not. This section has been expanded to provide further guidance in making determinations. The definition of self-employment has been expanded to further explain that "material participation" in a self-employment enterprise affects the amount of income generated; if a person participates less, the income also goes down, or when the person participates more, the income increases. When a person claims to be self-employed, evidence must be provided to substantiate the claim. Evidence may include a business license, registration of the business with the Secretary of State, advertising, regular transactions made in the business name, bank accounts, and/or charge accounts in the business name, and sustained, ongoing activity of the business. Independent contractors should be registered with the Montana Department of Labor and Industry. Although corporations may be thought of by the owners as self-employment enterprises, corporations are not self-employment enterprises. As such, property owned by the corporation and the stock owned by the shareholders cannot be excluded as necessary for self-employment. This is consistent with previous clarifications made to other sections of the Aged, Blind and Disabled Medicaid policy.

The manual currently states that in-kind income (for example food or shelter) received in return for self-employment activities should be prorated among the members of the family. This does not correctly state the department's policy. In-kind income received by several household members cannot simply be prorated among household members. A separate determination of in-kind income must be made for each member of a family or household, based on their own situation. It is therefore necessary to make this change to state correctly the department's policy. These clarifications are intended to avoid conflict and assist in supporting determinations, there is no fiscal impact expected from these changes.

MA 603-3 Income Deeming Computation for a Sponsored Alien -- As explained above under Section MA 400, Resources Overview, the resources of a sponsored alien, as well as the resources of the sponsor's spouse, if sponsor lives with his or her spouse, are considered in determining the alien's eligibility for Medicaid. Similarly, the income of the sponsor and the sponsor's spouse is deemed available to the eligible alien. The department proposes to make certain changes to the policy governing deeming of a sponsor's resources in order to make it less complicated. In order to simplify the calculation, the income of a sponsor's spouse will be treated the same whether the spouse is a cosponsor of the alien or not. Additionally, if two unmarried individuals are cosponsors of an alien, the income deeming calculation

will be the same as if the co-sponsors were a couple. If two cosponsors are both married and living with their spouses, each couple's income will be deemed to the sponsored alien(s) separately. No financial impact is expected as a result related to this change. Sponsored aliens rarely apply for Medicaid in Montana, and the amount of income deemed from the sponsor to the alien based on these changes is not expected to significantly impact eligibility. This is a procedural simplification with no significant fiscal impact anticipated.

MA 702-2 Cash Option Refund -- As explained in Section MA 002, Medically Needy, above, a person whose income exceeds the income limit for Medicaid eligibility may become eligible for Medicaid as a medically needy individual by incurring medical expenses equal to the difference between the medically needy income limit and the person's net countable income. A person whose income exceeds the Medicaid income limit also had the option of qualifying for Medicaid by making a cash payment to the department in an amount equal to the difference between the medically needy income limit and the person's net countable income. Persons who qualify by making a cash payment become eligible for Medicaid on the first day of the month, whereas Medicaid eligibility for those who become eligible by incurring medical expenses does not begin until the day after the individual's incurment for the month is met. A provision is now being added stating that households receiving Veterans Aid and Attendance (A&A) benefits cannot meet their medically needy incurment by using the cash payment option for reasons discussed below. The department is now specifying for the first time that households receiving A&A benefits cannot use the cash payment option because the department had not realized until now the reasons why use of the cash option is not appropriate for these households. The reason for this new policy is as follows:

The household must first pay medical expenses with the A&A benefit, which the Veterans Administration pays in addition to the regular monthly pension to help pay medical expenses for veterans who are bedridden, blind, who require the aid of another person to perform personal functions required in everyday living, or who are patients in a nursing home due to mental or physical incapacity. The A&A benefit is thus a third party payment for medical expenses. The department’s rule governing medically needy incurments, ARM 37.82.1107, provides that only expenses which are not the liability of a third party can be used to meet a medically needy incurment. Expenses that the household pays with its A&A benefit therefore cannot be used to meet the household's incurment. Only medical expenses incurred after the A&A benefit has been exhausted can be applied toward an incurment. Since the cash option results in Medicaid benefits being issued for the entire month, use of the cash option by a household receiving an A&A benefit could result in expenses that are intended to be covered by the A&A payment being paid by Medicaid. Therefore, households with Veterans A&A benefits must use the medical expense option. There is no fiscal impact to the program because of this change.

MA 904-2 Post-Eligibility Treatment of Income for Institutionalized Spouses -- After a person who resides in a nursing facility or other medical institution is found eligible for institutional Medicaid coverage, the department computes the amount of the

institutionalized person's income that must be applied toward the cost of institutional care. Certain deductions are made from the institutionalized person's gross monthly income to arrive at the person's contribution to the cost of care. This section specifies the allowable deductions used to compute the contribution to the cost of care for institutionalized spouses. Several changes are being made to this section. First, the personal needs allowance, which was $40 per month, is being increased to $50 per month because the Sixtieth Montana Legislature appropriated $256,509 of state special revenue dollars for fiscal years 2008 and 2009 to increase the personal needs allowance to $50.

The second change is the removal of the home maintenance allowance from the list of allowable deductions from income for an institutionalized spouse. The home maintenance allowance is being eliminated because the federal statute that sets forth allowable deductions from income for institutionalized spouses in computing the contribution to the cost of care, 42 USC 1396r-5(d), does not include a home maintenance allowance. The deduction is only allowed for institutionalized individuals. The third change in policy is in regard to the deduction for incurred medical expenses. A provision is being added that no deduction is allowed for nursing home expenses incurred during an asset transfer penalty period, that is, during the period of time when a person is ineligible for Medicaid nursing home benefits because of an uncompensated transfer of assets. It would defeat the purpose of penalizing uncompensated transfers by making the transferor ineligible for Medicaid if the transferor could then use the nursing home bills that accumulated during the penalty period to become eligible for Medicaid in a future month. This provision is being added now because the department has learned that in other states recipients are trying to use expenses incurred during penalty periods to meet their incurment for future months. Total fiscal impact of the change to the personal needs allowance is estimated to be an increase of $256,509 of state special revenue for 2008 and 2009. The other changes are not expected to have any significant fiscal impact.

MA 904-3 Post-Eligibility Treatment of Income for Institutionalized Individuals -- As discussed above in regard to MA 904-2, Post-Eligibility Treatment of Income for Institutionalized Spouses, Section MA 904-3 is being revised to state that the personal needs allowance has been increased from $40 to $50 due to an appropriation by the Sixtieth Montana Legislature for this purpose. As also discussed in regard to MA 904-2, above, Section MA 904-3 is being revised to state that nursing home expenses incurred during an asset transfer penalty period cannot be used to meet an incurment for a future month. Total fiscal impact of the change to the personal needs allowance is $128,255 from state special revenue. Incurred medical expense policy change is not expected to have fiscal impact at this time.

MA 1401-1 Estates Recovery -- The federal Medicaid statute at 42 USC 1396p(b)(1)(A) mandates that state Medicaid agencies seek to recover from the estates of deceased Medicaid recipients certain payments Medicaid has made on the recipients' behalf, namely, all payments for care in a nursing facility or certain other medical institutions, regardless of the recipient's age at the time the services

were furnished, if the recipient was permanently institutionalized, and all payments for home and community based services furnished when the recipient was 55 years of age or older. States also have the option to recover the amount paid for any type of service or item furnished when the recipient was 55 years of age or older. Section 53-6-167, MCA, requires the department to pursue estate recovery for all services provided to a recipient aged 55 or older as well as for nursing home services. This section of the manual currently provides that all that institutionalized individuals must sign form HCS-120 "Estate Recovery" as a condition of eligibility for Medicaid. This form notifies recipients of Medicaid estate recovery policies. By signing and returning the form, the individual acknowledges that he or she was notified of these policies. The manual currently does not require recipients of home and community based services to sign the form HCS-120. This was an oversight, since federal law has always required estate recovery for home and community based services provided when a person is over the age of 55. The policy is now being changed because it is important to ensure that recipients of home and community based services as well as nursing home residents are notified of estate recovery requirements and acknowledge that they have received such notice. This change has no fiscal impact.

Family Medicaid Manual

FMA 003 Medically Needy Income Levels -- The Sixtieth Montana Legislature appropriated $1.1 million of state special revenue dollars for fiscal years 2008 and 2009 to increase the amount of income that is disregarded in determining eligibility for the medically needy category of Medicaid. This appropriation will result in an additional $3.3 million in federal Medicaid matching funds, for a total of $4.8 million additional funds for the biennium. Persons or households whose income exceeds the maximum income limit for Medicaid eligibility although they otherwise qualify may become eligible for Medicaid as medically needy individuals by incurring medical expenses equal to the difference between the medically needy income limit and the person or household's net countable income. The difference between the medically needy income limit and the household's countable income is known as the household's medically needy incurment. If a household's countable income is lower, its incurment will be smaller, and it will be easier for the household to qualify for Medicaid. A household's countable income is calculated by subtracting certain income disregards, such as the $20 general income disregard or the $65 work expense disregard, from gross income. An increase in the amount of income disregarded in computing a household's income makes it easier for households to qualify for Medicaid as medically needy individuals.

The department is implementing the Legislature's mandate to count less income by allowing an additional deduction of $50 per month to be subtracted from each medically needy household's net countable income when determining the medically needy incurment. The new deduction will be $50 per month for all households, regardless of household size, beginning August 1, 2007. The deduction will increase to $100 per month effective July 1, 2008. The department chose to implement the Legislature's mandate to count less income by adding a deduction rather than by

raising the medically needy income limit because the medically needy income limit is based on the categorically needy income standards for Family Medicaid. Thus, an increase in the medically needy income limits would require an increase in the Family Medicaid categorically needy income standards which would make more families eligible for regular (nonmedically needy) Medicaid. This would increase Family Medicaid expenditures approximately $7 million annually. The department therefore opted to use a deduction from income instead. The department chose to deduct the same amount from the countable income of all households regardless of household size or other factors because this is simpler than adjusting the deduction amount depending on household size or other factors.

FMA 004 Pregnancy -- The Sixtieth Montana Legislature indicated its wish that the income limit used to determine eligibility for Pregnancy Medicaid be increased from 133% of the federal poverty level (FPL) to 150% of the FPL by appropriating $2.2 million of state special revenue dollars for fiscal years 2008 and 2009 for this purpose. Section 53-6-131(7), MCA, provides that Medicaid must be provided to pregnant women whose income does not exceed 133% of the FPL, but neither the federal nor the state Medicaid statute specifies how income must be calculated in determining an individual's income for Medicaid. The department therefore has increased the amount of income disregarded in determining eligibility for pregnancy Medicaid rather than increasing the income standards to expand eligibility for this coverage group in accordance with the Legislature's intent without actually increasing the income limit to 150% of the FPL. The department has consulted with the Centers for Medicare and Medicaid Services (CMS) regarding the use of higher income disregards to achieve expanded eligibility for this coverage group and was advised that this is acceptable to CMS. The fiscal impact is estimated at $2.2 million of health and Medicaid initiatives account special revenue and $2.5 million in federal Medicaid matching funds, for a total of $4.7 million for the biennium.

FMA 307-4 Estates Recovery -- The federal Medicaid statute at 42 USC section 1396p(b)(1)(A) mandates that state Medicaid agencies seek to recover from the estates of deceased Medicaid recipients certain payments Medicaid has made on the recipients' behalf, namely, all payments for care in a nursing facility or certain other medical institutions, regardless of the recipient's age at the time the services were furnished, if the recipient was permanently institutionalized, and all payments for home and community based services furnished when the recipient was 55 years of age or older. States also have the option to recover the amount paid for any type of service or item furnished when the recipient was 55 years of age or older. Section 53-6-167, MCA, requires the department to pursue estate recovery for all services provided to a recipient aged 55 or older as well as for nursing home services. This section of the manual currently provides that all that institutionalized individuals must sign form HCS-120 "Estate Recovery" as a condition of eligibility for Medicaid. This form notifies recipients of Medicaid estate recovery policies. By signing and returning the form, the individual acknowledges that he or she was notified of these policies. The manual currently does not require recipients of home and community based services to sign the form HCS-120. This was an oversight, since federal law has always required estate recovery for home and community based services

provided when a person is over the age of 55. The policy is now being changed because it is important to ensure that recipients of home and community based services as well as nursing home residents are notified of estate recovery requirements and acknowledge that they have received such notice. This change has no fiscal impact.

FMA 400 Resources Overview and FMA 401-1 Resource Ownership/Accessibility/ Equity Value -- The definition of when an asset is considered available has been restated to clarify that a resource is considered available if the individual has either a legal or equitable interest in the asset, and the resource is counted if the individual has the legal or equitable ability to access the funds or to convert noncash property into cash, regardless of their practical ability to do so. This is merely being added for clarification and does not represent a change in policy.

FMA 503-1 Self-Employment -- Differentiating between self-employment and hobbies, and between self-employment income and passive income from income producing property is often difficult. Whether an activity represents self-employment or not can make a difference to whether some resources are countable or excluded, and whether income is considered earned or unearned; both may make the difference between an individual qualifying for Medicaid or not. This section has been expanded to provide further guidance in making determinations. The definition of self-employment has been expanded to further explain that "material participation" in a self-employment enterprise affects the amount of income generated; if a person participates less, the income also goes down, or when the person participates more, the income increases. When a person claims to be self-employed, evidence must be provided to substantiate the claim. Evidence may include a business license, registration of the business with the Secretary of State, advertising, regular transactions made in the business name, bank accounts, and/or charge accounts in the business name, and sustained, ongoing activity of the business. Independent contractors should be registered with the Montana Department of Labor and Industry. Although corporations may be thought of by the owners as self-employment enterprises, corporations are not self-employment enterprises. As such, property owned by the corporation and the stock owned by the shareholders cannot be excluded as necessary for self-employment. This is consistent with previous clarifications made to other sections of the Aged, Blind and Disabled Medicaid policy.

The manual currently states that in kind income (for example food or shelter) received in return for self employment activities should be prorated among the members of the family. This does not correctly state the department's policy. In kind income received by several household members cannot simply be prorated among household members. A separate determination of in kind income must be made for each member of a family or household, based on their own situation. It is therefore necessary to make this change to state correctly the department's policy. This is consistent with previous clarifications made to other sections of the Family Medical Manual.

5. The department intends the amendment to be applied effective January 1, 2008.

6. Interested persons may submit comments orally or in writing at the hearing. Written comments may also be submitted to Rhonda Lesofski, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena MT 59604-4210, no later than 5:00 p.m. on November 23, 2007. Comments may also be faxed to (406)444-1970 or e-mailed to dphhslegal@mt.gov. The department maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. To be included on such a list, please notify this same person or complete a request form at the hearing.

7. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of this notice conform to the official version of the notice as printed in the Montana Administrative Register, but advises all concerned persons that, in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. The web site may be unavailable at times, due to system maintenance or technical problems.

8. The bill sponsor notice requirements of 2-4-302, MCA, do not apply.

9. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct the hearing.

/s/ Barbara Hoffmann
Rule Reviewer

/s/ Joan Miles
Director, Public Health and Human Services

Certified to the Secretary of State October 15, 2007.